STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003154	A. BUILDING: _____ B. WING _____	C 12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HOSPICE SERVICES	931 E 86TH ST STE 208 INDIANAPOLIS, IN 46240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a state complaint investigation. Complaint #: IN00140722 - Unsubstantiated: Lack of sufficient evidence. Survey Date: December 27, 2013 Facility #: 003154 Medicaid Vender #: 200142900B Surveyor: Tonya Tucker, RN, PHNS Heartland Hospice Services is in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418.52 (c)(1), (c)(6), 418.54 (c), and 418.64 (b) as related to this complaint. Quality Review: Joyce Elder, MSN, BSN, RN January 2, 2014	S 000		